CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

CHAPTER IV
COVERED SERVICES AND LIMITATIONS

COVERED SERVICES

Health services provided by school divisions and covered by Medicaid include all of the following:

- Physical therapy, occupational therapy, and speech-language pathology services;
- Hearing screenings; and
- EPSDT screenings and outreach services.

School divisions employing qualified physical therapists, occupational therapists, and/or speech-language pathologists provide rehabilitative services. Children who receive the rehabilitative services have special education needs. Personnel trained to administer hearing screens conduct hearing screens on the children with special education needs.

These rehabilitative services must be prescribed by a physician, be a part of a written plan of care and reviewed periodically by the physician. The physician must certify that the service is medically necessary and that the treatment prescribed is in accordance with standards of medical practice.

Each school division must have a valid provider agreement with the Department of Medical Assistance Services for the type of services that are being provided to be reimbursed for services rendered. The rehabilitative services must be part of the child's plan under the Individualized Education Program (IEP). Hearing screenings do not need to be in the IEP and do not require certification by a physician.

When the school division knows that a child has a Medicaid primary care physician (PCP), information about Medicaid-reimbursed school services are to be promptly communicated to the physician by the school division. This is applicable even in the event of EPSDT screenings where the results are normal. This is also applicable whether the child is participating in MEDALLION II, *Options*, or other programs that employ a primary care physician. The school health services are exempt from MEDALLION; however, coordination of services is required with the child’s PCP.

CATEGORIZATION OF TWO SUB-GROUPS: ACUTE VS. NON-ACUTE CONDITIONS

Effective July 1, 1995, the Department of Medical Assistance Services (DMAS) categorizes general physical out-recipient rehabilitation into two subgroups: acute conditions and long-term, non-acute conditions. Acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration of less than

12 months, and in which progress toward established goals is likely to occur frequently. Long-term, non-acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration greater than 12 months, and in which progress toward established goals is likely to occur slowly.

Hospitals, rehabilitation agencies, and home health agencies, but not school divisions may provide services addressing acute conditions. Services addressing long-term, non-acute conditions may be provided by outpatient settings of hospitals, rehabilitation agencies, and school divisions.

A physician re-certification is required at least annually for long-term, non-acute rehabilitative services. This requirement for physician re-certification does not supersede conditions of participation for home health providers who may be treating recipients in either subgroup. The physician review and re-certification of the home health plan of treatment must be completed at least every 62 days, for all recipients, according to federal requirements. Physician certification (plan of care) prior to the start of services, and the required periodic re-certification (plan of care renewal) must be signed and dated by the physician prior to the initiation or the continuation of service. The physician who reviews the plan of care and certifies or re-certifies the need for service must sign the document.

Defining a condition as long-term or non-acute is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of care remains unchanged. Plans of care must still include measurable long-term goals with anticipated dates of achievement. Plans of care must be renewed by the physician at any time long-term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual recipient.

CRITERIA FOR THE PROVISION OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

A physician must prescribe physical therapy, occupational therapy, or speech-language pathology services.

Physical therapy, occupational therapy, and speech-language pathology services are medically prescribed treatment for providing diagnostic, therapeutic, and restorative services to the injured or disabled recipient. Any of these services shall not be contingent upon the provision of another service. The following Medicaid rules pertain to these services:

Physical Therapy

Physical therapy services are those services furnished to a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a

licensed physical therapist.

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Medicine or a physical therapy assistant licensed by the Virginia Board of Medicine under the direct supervision of a licensed physical therapist.

- The services must be provided with the expectation, based on the assessment of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time; or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

- The services must be specific and must provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

- Physical therapy services must be part of the child's Individualized Education Program plan.

- The school division must provide a program of physical therapy that has an adequate number of qualified personnel and the necessary equipment to carry out its program and to fulfill its objectives. An out-recipient physical rehabilitation program is considered to be adequate if it can:

  - Provide services utilizing therapeutic exercise and the modalities of heat, cold, water, and electricity;
  - Conduct recipient evaluations; and
  - Administer tests and measurements of strength, balance, endurance, range of motion, and the activities of daily living.

- A qualified physical therapist is present or readily available to offer needed supervision to the physical therapist assistant when physical therapy services are provided on or off of the school premises. When a qualified physical therapist is not on the premises during all of the hours of operation, recipients must be scheduled to ensure the physical therapist's presence when specific skills are needed (e.g., at the time of the evaluation and re-evaluation and to provide the appropriate and needed supervision to the physical therapist assistant providing services). When physical therapy services are provided off the premises by a qualified physical therapist assistant, such services are provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days.

- When personnel are available to assist qualified physical therapists by performing services incidental to physical therapy that do not require professional knowledge and skill, such personnel must be instructed in appropriate recipient care services by qualified physical therapists who retain

the responsibility for the treatment prescribed by the attending physician. Services rendered by personnel other than a licensed physical therapy assistant are not reimbursable.

- The school division must have the equipment and facilities required to provide the range of services necessary in the treatment of the types of disabilities accepted for service.

The more common physical therapy modalities and procedures are illustrated below.

Gait Training

Gait evaluation and training that is furnished to a recipient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a licensed physical therapist and constitutes physical therapy, provided that it can reasonably be expected to significantly improve the recipient's ability to walk. Examples of services that do not constitute rehabilitation physical therapy are:

- Repetitious exercises to improve gait, maintain strength, endurance, and assistive walking (such as that provided in support for feeble or unstable recipients);

- Activities appropriately provided by supportive personnel (e.g., aides or nursing personnel); and

- Activities that do not require the skills of a licensed physical therapist or licensed physical therapist assistant.

Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specified diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Those exercises, whether because of their nature or the condition of the recipient, may be performed safely and effectively only by a licensed physical therapist or under the direct supervision of the therapist and, therefore, will be considered rehabilitation therapy.

Generally, range of motion exercises that are not related to the restoration of a specific loss of function can ordinarily be provided safely by supportive personnel; such as aides or nursing personnel, and do not require the skills of a licensed physical therapist or licensed physical therapy assistant, and will not be considered rehabilitative care. Usually, passive exercises to maintain range of motion in paralyzed extremities can be carried out by aides or nursing personnel and will not be considered rehabilitative care.

Temporary Loss of Function

Generally, physical therapy is not required to improve or restore function where a recipient

suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) that could reasonably be expected to spontaneously improve as the recipient gradually resumes normal activities. Physical therapy for a temporary loss of function will not be covered.

Ultrasound, Short-wave, and Microwave Diathermy Treatments

These modalities must always be performed by or under the direct supervision of a licensed physical therapist and, therefore, constitute covered physical therapy.

Therapeutic Exercises

Therapeutic exercises performed by or under the direct supervision of a licensed physical therapist due to either the type of exercise employed or the condition of the recipient constitute covered physical therapy.

Hot Pack, Hydrocollator, Infrared Treatments, and Whirlpool Baths

Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a licensed physical therapist. However, in a particular case, the skills, knowledge, and judgment of a licensed physical therapist might be required in giving such treatments or baths (e.g., where the recipient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications).

Occupational Therapy

Occupational therapy services are those services furnished a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine.

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a qualified occupational therapist or an occupational therapy assistant (COTA) certified by the National Board for Certification in Occupational Therapy under the direct supervision of a qualified occupational therapist.

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

- Occupational therapy services must be part of the child's Individual Education Program plan.

- The school division must provide an adequate program of occupational therapy that has an adequate number of qualified personnel and the equipment necessary to carry out its program and to fulfill its objectives. An out-recipient occupational therapy program is considered to be adequate if it can:

    - Provide services utilizing therapeutic exercise;
    - Conduct recipient evaluations; and
    - Administer tests and measurements of strength, balance, endurance, range of motion, and the activities of daily living.

- A qualified occupational therapist is present or readily available to offer needed supervision to the occupational therapy assistant when occupational therapy services are provided. Where a qualified occupational therapist is not on the premises during all hours of operation, recipients are scheduled in such a manner as to ensure the occupational therapist's presence when specific skills are needed (e.g., evaluation and re-evaluation and to provide appropriate supervision to the occupational therapist assistant when providing services). When occupational therapy services are provided off the premises by a qualified occupational therapy assistant, such services are provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days.

- The out-recipient occupational therapy services provider must have equipment and facilities required to provide the range of services necessary for treatment of the types of disabilities accepted for service.

- If personnel other than the occupational therapy assistant are available to assist qualified occupational therapists by performing services incidental to occupational therapy that do not require professional knowledge and skill, such personnel are instructed in the appropriate recipient care services by qualified occupational therapists who retain the responsibility for the treatment prescribed by the attending physician.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the recipient's level of function and develop a plan of treatment, the implementation of the plan may be carried out by a qualified occupational therapy assistant functioning under the direct supervision of a qualified occupational therapist.

Occupational therapy may involve some or all of the following procedures:

- The evaluation and re-evaluation, as required, to assess a recipient's level of function by administering diagnostic and prognostic tests;

- The selection and teaching of task-oriented therapeutic activities designed to restore physical function (e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns);
- The planning, implementing, and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of sewing activities that require following a pattern to improve sequencing or restore reality orientation cognitive functioning in a neurologically impaired recipient);

- The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke recipient with functional loss resulting in a distorted body image);

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a recipient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a stroke recipient new techniques to enable him or her to perform feeding, dressing, and other activities as independently as possible); and

- Vocational or prevocational assessment and prevocational training.

Speech-Language Pathology Services

Speech-language pathology services are those services furnished a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology (42 CFR 440.110);

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that any one of the following can only perform the services:
  A Masters level prepared speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology; *or*

  An individual who meets one of the following:
  (a) has a Certificate of Clinical Competence (CCC) from the American Speech

and Hearing Association (ASHA); *or*
(b) has completed the equivalent education requirements and work experience necessary for the certificate; *or*
(c) has completed the Masters level academic program and is acquiring supervised work experience to qualify for the ASHA certification *or* the Virginia Board of Audiology and Speech-Language Pathology licensure. This individual is in the Clinical Fellowship Year (CFY), typically a nine (9) month supervision. This individual must be under the direct clinical supervision of a CCC/SLP. When services are provided by a CFY/SLP, a CCC/SLP must make a supervisory visit at least every 30 days and document accordingly;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

- The services must be specific and must provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

- Speech-language pathology services must be part of the child's Individualized Education Program p lan.

- If speech pathology services are offered, the agency or facility must provide an adequate program of speech pathology and have an adequate number of qualified personnel and the equipment necessary to carry out its program and to fulfill its objectives. An adequate outrecipient speech pathology program is one that can provide the diagnostic and treatment services to effectively treat speech disorders;

- The school division must have the equipment and facilities required to provide the range of services necessary in the treatment of the types of speech disorders accepted for service.

- Speech pathology services are given or supervised by a qualified speech pathologist, and the number of qualified speech pathologists is adequate for the volume and diversity of speech pathology services offered. At least one qualified speech pathologist is present at all times when speech pathology services are rendered.

Speech-language pathology services include the following procedures:

- Assisting the physician in evaluating recipients to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech pathologist of a recipient with aphasia following a recent stroke to determine the need for speech-language pathology services and

- Providing rehabilitative services for speech and language disorders.

Therapy Guidelines

The following illustrate the application of the above guidelines to some of the more common rehabilitative therapy modalities and procedures:

- **Improvement of Function** - Rehabilitative therapy designed to improve function must be based on an expectation that the therapy will result in a significant practical improvement in a recipient's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the rehabilitative therapy program is instituted, the services will be recognized even though the expectation may not be realized. This applies only up to the time that is reasonable to conclude that the recipient is not going to improve.

- **Maintenance Therapy** - Maintenance therapy is defined as the point where no further significant practical improvement can be expected or the skills of a rehabilitative therapist are not required to carry out an activity or exercise program to maintain function at the level to which it has been restored. Therefore, maintenance therapy is not a covered rehabilitation service.

Preauthorization Process

Up to twenty-four (24) visits per service are covered annually for physical therapy, occupational therapy, and speech-language pathology services provided by schools. Limits are per discipline and recipient-specific, regardless of the number of providers rendering the services. "Annually" is defined as July 1 through June 30 for each recipient. The school must maintain documentation to justify the need for services. Preauthorization by DMAS is required before payment will be made for any visits over 24 per year.

Preauthorization is required for outpatient rehabilitation visits in excess of 24. Beginning with dates of service on or after October 1, 1998, the option of mailing in a DMAS-351 with attached documentation to request preauthorization for outpatient rehabilitation is no longer available. Preauthorization may be obtained only by calling the WVMI at (800) 299-9864 or (804) 648-3159 prior to the completion of the 24th visit. WVMI may request that certain documentation or an entire request be faxed. Telephonic preauthorization must be obtained prior to rendering services. When preauthorization is requested, WVMI will inform the provider of the status of the request (approve, deny, append, reject). If the request is approved, WVMI will indicate the amount of time approved. If treatment is needed beyond this time frame, the provider must call and request preauthorization prior to the end of the previously approved time period. In the event that treatment has continued with a lapse in authorizations, authorization may begin on the day it is requested if the criteria are met. Requests submitted in writing for dates of services on or after October 1, 1998 would be rejected; and the provider will receive a notice reminding him of the telephonic preauthorization process. Any services provided without preauthorization will not be reimbursed. The initial therapy evaluation is included in the 24 visit preauthorization limitation.

The only exception to telephonic preauthorization is in cases of retroactive eligibility. The provider may request retroactive authorization in these cases either telephonically or in writing using the DMAS-351. (See "EXHIBITS" at the end of this chapter for a sample of this form.)

The purpose of preauthorization is to validate that the service requested is medically necessary and that it meets DMAS criteria for coverage. **Preauthorization does not automatically guarantee payment for the service; payment is contingent on passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. For services to be paid, all preauthorization criteria must be met.** Authorizations are specific to a recipient, a provider, a service code, an established quantity, and for specific dates of service. If a submitted claim for an item or service requiring preauthorization does not match the authorization exactly, the claim will pend for review or be denied.

Authorization for extended services shall be based on individual need. Periods of care beyond those allowed and not authorized by DMAS shall not be approved for payment.

To submit a preauthorization request on paper, mail the DMAS-351 Preauthorization Request form and supporting documentation to First Health Services Corporation, the DMAS fiscal agent. The address is:

FIRST HEALTH Services Corporation
P. O. Box 27444
Richmond, Virginia 23261-7444

FIRST HEALTH Services Corporation will data enter the paper request for preauthorization and forward it to WVMI. Make telephonic requests for preauthorization directly to WVMI at the following telephone numbers:

(804) 648-3159 Richmond Area
(800) 299-9864 All Other Areas

The turnaround time for providers receiving a response to a paper preauthorization request is about two weeks. In most cases, an immediate response will be provided to telephonic requests.

Mail pend responses and reconsideration requests directly to WVMI. The address is:

WVMI
Richmond Nationsbank Center - Floor 4
1111 East Main Street
Richmond, Virginia 23219

Direct all telephone inquiries regarding the preauthorization status to the DMAS provider HELPLINE. Information pertaining to preauthorization status is no longer available to other DMAS staff.
WVMI will accept changes and deletions for preauthorization requests by fax. To submit

changes, send a completed DMAS-351, signed and dated by a qualified professional. The DMAS-351 must include the tracking number to be changed, the HCPCS codes affected, the total number of units needed, and the dates requested. In Section VII, under provider comments, explain the change. To request a deletion, send a completed DMAS-351 including the tracking number to be deleted. When a deletion is made, all units and dates for the tracking number are deleted. If any of the units and dates have been used, submit a change. The fax numbers for WVMI are:

Richmond	804-648-6880
All other areas	888-243-2770

If the WVMI review analyst denies services and the provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If the WVMI review analyst denies a telephone request, the provider must request telephonic reconsideration by the WVMI Preauthorization Supervisor within 30 days of the denial. If the WVMI analyst denies a written request, the provider must submit a letter to the WVMI Preauthorization Supervisor requesting reconsideration within 30 days of the notice of denial. The provider may request reconsideration of the denial by submitting a written request to:

WVMI, Preauthorization Supervisor
Richmond Nationsbank Center, Floor 4
1111 East Main Street
Richmond, VA 23219

After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial of the reconsideration. All written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Claims for services, which exceed the sessions available to the recipient without authorization, will be denied. DMAS is not responsible for claims denied because the service limit has been reached. To check if authorization is required (the individual has utilized all 24 initial sessions or all of the sessions subsequently authorized), call the Medicaid provider HELPLINE at 1-800-552-8627; provide the individual's Medicaid number; and ask for the record of utilization. The claims history file contains information on paid claims. If a claim has not been paid, the number of available sessions will be overstated. Ask the recipient whether he has seen anyone else; check your records for any services provided but not paid; and ask when calling the HELPLINE whether any other provider has indicated on the file and the last date of service for which a claim was paid.

An example of the current version of the DMAS-351 form is found in "EXHIBITS" at the

end of this chapter. Additional DMAS-351 forms may be obtained by completing a copy of the order form shown in Chapter V (DMAS-161) and sending it to:

DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, Virginia 23222

The DMAS-351 form is supplied in pads of 50. Only the DMAS-351 form supplied by DMAS or its plain paper photocopy may be used.

DMAS-351 Completion

Instructions for completing the DMAS-351 form are found on the reverse side of each request form. The following are points of clarification for use when completing the DMAS-351.

Section I: Transaction Type

- **Original**: Use for all new requests. All sections of the DMAS-351 (Section I through Section VII) must be filled out completely and accurately.

- **Change**: Use when requesting a change to a previously approved request; **change the service code, quantity of units, or dates of service.** When submitting a "change" request, write the original preauthorization (tracking number) number in Section I of the DMAS-351 and mark "change." **Do not submit a "change" request for any item that has been denied or is pended.**

  Complete Section I through Section III when submitting a "change" request. Sections V and VI only need to be filled out if there is a change within those sections. Section VII must be completed for each line that requires a change to any box. Identify the service code to be changed and insert the changes made in the appropriate columns in Section VII. (If the change requests additional quantities or a longer period of time, appropriate justification must be attached.) **Enter the reason for the change request in the Provider Comment Section.**

  To correct an incorrect service code (HCPCS, CPT, or NDC), identify in the comment section the approved code to be changed and fill out section VII completely for each new service code requested. To void a service code (i.e., completely void a line item), identify the service code to be voided in the comment section and include this statement "Void this service code." DMAS will only take action on this service code; the action status on other service codes under the same preauthorization number will not be changed.

  To submit a "change" request for a miscellaneous code, identify the original HCPCS modifier for each miscellaneous code that requires a change. The provider must sign and date the change request.

- **Delete:** Use when you want to void **all of the items under one**

preauthorization number. For example, use "delete" when you have received authorization under the wrong recipient or provider number and you wish to delete the entire request. All service codes under the identified preauthorization number will be deleted. Do not submit a "delete" request if you only want to change a portion of an approved preauthorization number. **You may not "delete" a request that has been denied.**

Completely fill out Sections I through Section III when submitting a "delete" request. The provider must sign and date the delete request.

Section II: Provider Information

Submit the appropriate seven-digit Medicaid provider number. Requests submitted by a provider for a date of service on which the provider was not enrolled with DMAS will be rejected.

Identify a contact person and phone number of someone in the organization who will be able to answer or coordinate the answers to any questions that DMAS may have regarding the request in the comment section. Authorizations are specific to a provider number and may not be shared with any other provider.

Changes in Provider Number

- If a new provider number is issued, all approvals issued under the old provider number for dates of service to be provided under the new provider number **must be transferred** to the new provider number.

- To request this change, the provider must submit a "change" request under the old provider number and identify the appropriate end date for each service code authorized (but not billed for), and then submit an "original" request under the new provider number with the appropriate quantities and new begin date.

- In the comment section of each new "original" request, the provider must state "Change of ownership; item previously approved under (insert old provider number) provider number."

- In these situations, DMAS will transfer the "original" authorizations as approved; **any changes required must be submitted as a "change" request after the transfer of the approval to the new provider number.**

Section III: Recipient Information

The recipient's 12-digit Medicaid number must be complete and valid for the dates of service requested. (Numbers ending in "00-*" ARE NOT VALID RECIPIENT NUMBERS.) Virginia Medicaid recipients are eligible on a monthly basis; therefore, a recipient eligible in January may become ineligible in March. The provider must verify the Medicaid eligibility of the recipient every time a service is delivered. The provider must see the recipient's current Medicaid card each time a service is delivered. As an alternative, call the Audio Response System (ARS) to verify recipient eligibility. ARS is available 24-

hours-per-day, seven-days-a-week.

The numbers are:

1-800-884-9730	Outside of Richmond Calling Area
804-965-9732	Richmond and Surrounding Counties
804-965-9733	Richmond and Surrounding Counties

Providers access the ARS by using their Virginia Medicaid provider number as identification. By entering the recipient identification number or the Social Security Number and date of birth, the provider receives responses for up to three dates of service per recipient, and up to 10 individual recipients may be verified per call. The provider must provide Medicare or other insurance information on the DMAS-351 or claim when aware of other insurance coverage.

Section IV: Referral Source Information

Schools do not complete Section IV.

Section V: Program Category

Select the appropriate program from which the recipient is eligible to receive requested services. Only select **one** category per preauthorization request. Multiple selections result in the request's being rejected.

- Select **Rehab Unit** category for outpatient rehabilitative services (i.e., physical therapy, occupational therapy, and speech-language pathology services) provided by schools.

Section VI: Service Category

Select the service category describing the service code requested; only select one category per preauthorization request. **School division providers will select "Rehab" for physical therapy, occupational therapy, and speech-language pathology services.**

Section VII: Request Information

Identify the specific HCPCS code being requested. Outpatient rehabilitative services must be requested by the appropriate code identified for the type of service and type of provider. The preauthorization file will not recognize specific CPT or NDC codes for rehabilitative services. Narrative descriptions will not be accepted. HCPCS codes for services provided by school divisions are:

HCPCS Code	Description
Rehabilitative Services	
Z9450	**Physical Therapy Assessment**

Z9451	**Physical Therapy, Individual Session**
Z9452	**Physical Therapy, Group Session**
Z9453	**Occupational Therapy Assessment**
Z9454	**Occupational Therapy, Individual Session**
Z9455	**Occupational Therapy, Group Session**
Z9456	**Speech/Language Assessment**
Z9457	**Speech/Language, Individual Session**
Z9458	**Speech/Language, Group Session**

Individual and group out-recipient rehabilitative therapy sessions are anticipated to last 35-45 minutes, except where stated otherwise. Group sessions must not exceed three children.

- Units Requested: Therapies must be submitted as a visit. A visit is defined as the treatment session in which a rehabilitation therapist is with a client to provide covered services prescribed by a physician. **Visits are not defined in measurements or increments of time except where indicated.** The furnishing of any services by a therapist on a particular day or at a particular time of day constitutes a visit. Visits and units are used interchangeably.

  Identify only the number of visits/units necessary **in excess** of the established allowable. Place numbers only in the units requested block. The amount requested should reflect the amount required for the entire from and through dates of the request beyond the established visit limit. Calculations (e.g., 2 X week X 36 weeks) or other such entries cannot be keyed and will be rejected.

- Actual Cost: This column is not used by school providers.

- Total Dollar Requested: This column is not used by school providers.

- Dates of Service: Identify the dates of services for which the corresponding services codes are requested. Write dates in numerical form (e.g., June 1, 1999, is written 06/01/99).

Definition of a Rehabilitative Therapy Visit

A visit is defined as the treatment session that a rehabilitation therapist or other health worker is with a recipient to provide covered services prescribed by a physician. Visits are not defined in measurements or increments of time. The furnishing of any services by a particular health worker on a particular day or at a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services on the same day, this constitutes two visits. If a therapist furnishes several services during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy visits in the same day (e.g., a morning session and an afternoon session), this constitutes two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a

single procedure). The overall goal(s) of the visit determines how the visit can be billed.

It is critical that there be excellent communication and coordination between the school therapist and any external therapist involved in seeing the child. This necessitates careful education of the child's parents, including written communication to the child's parent (or legal guardian) regarding dual rehabilitative services. In the event that the child receives dual rehabilitative services, it is the responsibility of both rehabilitation providers to seek preauthorization when the 24 visits are exhausted. Coordination of services between rehabilitation providers allows each provider to determine when PA is required.

TERMINATION OF SERVICES

Services will terminate when further progress toward the established goals is unlikely or it is appropriate to assume that therapy treatments can be maintained or provided by the recipient, family, care aide, etc. When someone can provide care other than the health care professional therapist, DMAS will not reimburse for services. Specifically, if no further progress is observed, discharge is appropriate. Orders for discharge must be signed and dated by the physician.

CRITERIA FOR SCHOOL-BASED CLINIC SERVICES

Overview

The Medical Assistance Program is designed to assist eligible Medicaid recipients in obtaining medical care within the guidelines specified in this manual and the Virginia *State Plan for Medical Assistance*. Medicaid reimburses for covered services (listed in Chapter I) provided based upon medical necessity. DMAS defines "medically necessary services" as those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the function of a malformed extremity. Coverage may be denied if the requested service is not medically necessary according to the preceding criteria or is generally regarded by the medical profession as experimental or unacceptable.

Consistent with federal regulations, clinics (including school-based health clinics) must be under the direction of a physician. All providers must be qualified to render services as required under State law.

Services provided at no charge to the general public cannot be billed to Medicaid.

School divisions billing clinic services to DMAS are those that have been selected to receive funds under the school-based health center program administered by the Department of Education.

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a program that provides preventive health care to Medicaid-eligible individuals from birth to age 21. The medical services under EPSDT are fully described in the EPSDT Supplement.

DMAS reimburses school divisions for EPSDT screenings. The screenings and other information are described in the EPSDT Supplement.

Criteria for the Provision of Vision and Hearing Screenings

Vision and hearing screenings are covered under the EPSDT program. The EPSDT Periodicity Schedule regulates the frequency of screenings for most children. An objective screening method shall be utilized with children who are able to cooperate. Refer to the EPSDT Supplement for specific screening methods and reimbursement requirements.

Vaccines

The Vaccines for Children (VFC) Program provides routine childhood vaccinations free of charge to Medicaid-eligible children up to the age of 19. The Virginia Department of Health (VDH) will provide these vaccines.

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC. Upon enrollment, the Department of Medical Assistance Service will not reimburse the provider for vaccines covered under VFC. Refer to the EPSDT Supplement of this manual for the VFC/EPSDT immunization schedule and reimbursement requirements.

Outreach Services

Outreach services are an integral part of the Medicaid Program, as they allow children and their parents to be informed of the importance of enrolling in Medicaid and the accessibility of services. In addition, outreach services can assist in reducing the number of children who are enrolled with Medicaid but do not participate in screenings and other services. The audience for outreach services is groups of students, parents, health care professionals, and others with an interest in improving the health status of children in the community. While outreach in the schools is covered by DMAS, case management is not covered because it involves direct services to individuals. Medicaid coverage of outreach services provided by school-based health clinics includes the following components:

- Describing how to participate in Medicaid and EPSDT;
- Informing children and guardians about EPSDT services, and promoting the advantages of early detection and treatment;
- Monitoring children's health needs according to the periodicity schedule and informing guardians about screenings and through general notices. (The discussion of actual screening results is covered under the screening billing codes in Chapter V.);
- Assisting with referral of the children to medical services through general notices;
- Coordinating EPSDT services with other services such as those offered by the

local health department and the Community Services Board;

- Informing children and guardians about anticipated physical and mental development, healthy lifestyles, and accident and disease prevention; and
- Organizing activities that emphasize preventive health care and promote EPSDT services.

The following information is to guide the delivery of outreach services:

- Outreach services must be under the direction of the outreach coordinator. The outreach services coordinator must be at a minimum a Registered Nurse, licensed by the Virginia Board of Nursing. The outreach coordinator should have a year of experience in community health nursing and experience in working with children.

- The outreach services aides must have adequate training to include maternal and child health care, human development, disease prevention and healthy lifestyles, EPSDT components, availability of community resources, and communication skills;

- Outreach services coordinators and aides must be employees of the school division;

- Billing for outreach services is through the use of the Medicaid Program School Based Clinic Services Quarterly Match Certification - Administration form described in Chapter II;

- Only Medicaid-eligible children may receive services for which Medicaid funding is provided;

- Information on Medicaid-eligible children is be maintained in a confidential manner. This information must be disclosed only in conjunction with a claim or when the data are necessary for the functioning of the State Agency;

- The school division must have a current agreement for Medicaid coverage of outreach as described in Chapter II.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapters I, III and VI of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for outpatient services to these recipients only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the recipient;

- On written referral from the primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.

- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

The primary health care provider must complete a Practitioner Referral Form (DMAS-70) when making a referral to another physician or clinic (see "EXHIBITS" at the end of this chapter for a sample of this form). The appropriate billing instructions for these situations are covered in Chapter V. Covered outpatient services excluded from this requirement include:

- Renal dialysis clinic services;

- Routine vision care services (routine diagnostic exams for recipients of all ages and eyeglasses for recipients under age 21) provided to restricted recipients; (NOTE: Medical treatment for diseases of the eye and its appendages still requires a written referral or may be provided in a medical emergency.)

- Baby Care services (nutrition, care coordination, or nurse midwife services);

- Personal care services (respite care or adult day health care);

- Ventilator-dependent services; and

- Prosthetic services.

These services must be coordinated with the primary health care provider whose name appears on the recipient's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

CLIENT APPEALS OF THE DENIAL OF SERVICES

Medicaid denial of covered services will not reduce the scope of services being provided by the schools; schools will not stop providing the services because criteria for Medicaid reimbursement were not met. Therefore, copies of Medicaid denials will not be sent to the recipient. All reimbursement denials will be managed through the provider appeal process discussed in Chapter VI.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low-income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

<u>QMB Coverage Only</u>

Recipients in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit less the recipient's copayment on allowed charges for all Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB--MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

EXHIBITS

EXHIBITS TABLE OF CONTENTS

SECTION I: TRANSACTION TYPE

____ Original
____ Change
____ Delete

Tracking Number: _____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRE AUTHORIZATION REQUEST

Date Received

Mail request to: ATTN: _____ (See Section V)
DMAS PRACTITIONER
P. O. Box 27444
Richmond, Virginia 23261-7444

SECTION II: PROVIDER INFORMATION

Provider Name _____ Provider No: _____

Address:
Street _____ City _____ State _____ Zip _____

Contact Person: _____ Telephone: (_____) _____-_____

SECTION III: RECIPIENT INFORMATION

Recipient Name:

Recipient No.: _____ (Last) _____ (First) _____

Address:
Street _____ City _____ State _____ Zip _____

Telephone: (_____) _____-_____ Recipient's Birth Date: ____-____-____

Other Insurance: _____ Medicare Number: _____

SECTION IV: REFERRAL SOURCE INFORMATION

Provider Name _____ Provider No.: _____

Address:
Street _____ City _____ State _____ Zip _____

Contact Person: _____ Telephone: (_____) _____-_____

SECTION V: PROGRAM CATEGORY

Check ONE Appropriate Category (Mail to Attention of:)

CBC PROGRAM:
____ EPSDT (1)
____ Waiver (2)
____ Outpatient Psych (3)

HOME HEALTH:
____ Home Health (6)
____ DME (7)

MED. SUPPORT:
____ Medical Services (4)
____ Other Services (5)

REHAB UNIT:
____ Rehab (8)

SECTION VI: SERVICE CATEGORY

(Check One Appropriate Category)

____ DME (1)
____ Practitioners (2)
____ Pharmacy (3)
____ Inpt. Psych (4)
____ Outpt. Psych (5)
____ Other (6)
____ Home Hlth (7)
____ Rehab (8)
____ Hospital (9)

SECTION VII: REQUEST INFORMATION

	HCPCS / CPT Code / NDC / Revenue Code	HCPCS Modifier	Units Requested	Actual Cost per Unit	Total Dollar Request	Dates of Service From	Dates of Service Thru
(1)						__/__/__	__/__/__
(2)						__/__/__	__/__/__
(3)						__/__/__	__/__/__
(4)						__/__/__	__/__/__
(5)						__/__/__	__/__/__
(6)						__/__/__	__/__/__

SECTION VIII: DMAS USE ONLY: Do Not Write in This Section

ACTION STATUS	Approved Units	Approved Dollars/Units	Approved Dates From	Approved Dates Thru	Action Reason	Initials and Date
A ____ D ____ P ____			__/__/__	__/__/__	____	__ __ __ / __ __
A ____ D ____ P ____			__/__/__	__/__/__	____	__ __ __ / __ __
A ____ D ____ P ____			__/__/__	__/__/__	____	__ __ __ / __ __
A ____ D ____ P ____			__/__/__	__/__/__	____	__ __ __ / __ __
A ____ D ____ P ____			__/__/__	__/__/__	____	__ __ __ / __ __
A ____ D ____ P ____			__/__/__	__/__/__	____	__ __ __ / __ __

Provider Comments

Provider Signature _____ Date _____

Comments

DMAS 351 5/94

ATTACH DOCUMENTATION OF MEDICAL NECESSITY

INSTRUCTION FORM - PRE AUTHORIZATION REQUEST

SECTION I: Transaction Type

Check appropriate Transaction:
- Original - use for new requests
- Change - use for adjustment of original request
- Delete - use for void of original request

(Original tracking number must appear on all requests for changes and/or deletions)

SECTION II: Provider Information (Provider who will deliver and bill for requested service)

- **Provider Name:** Complete Address of Provider
- **Provider No.:** Complete Provider Number (7 DIGITS)

  Complete Address of Provider
  Identify locality that service is being provided from; (All correspondence will be sent to the address identified on your provider agreement)
- **Contact Person:** Identify the contact person for DMAS to call if the reviewer has questions
- **Telephone No.:** Identify the telephone number of the contact person (Including Area Code)

SECTION III: Recipient Information

- **Recipient No.:** Complete Medicaid Number (12 DIGITS)
  It is your responsibility to verify Recipient Medicaid eligibility before submitting request or providing items
- **Recipient:** Recipient's Full Name (Last & First Name)
- **Address:** Complete Address of Recipient (use current address of Medicaid Recipient; include box #, street address, city, state and zip code)
- **Telephone No.:** Complete Telephone Number of Recipient (Including area code)
- **Date of Birth:** Full Date of Birth (MONTH, DAY, YEAR)
- **Medicare No.:** Complete Medicare Number (10 DIGITS)
- **Other Insurance:** Identify any other insurance that the recipient has (include the name of the insurance carrier and the policy number if available)

SECTION IV: Referral Source Information (If the Provider making a referral for the requested services is not the same Provider who will deliver the service, this section should be completed)

- **Provider Name:** Full Name of Provider
- **Provider No.:** Complete Provider Number (7 DIGITS)
- **Address:** Complete Address of Provider (Use the current address of the referral source; include box number, street address, city, state and zip code)
- **Contact Person:** Identify the contact person for DMAS to call if the reviewer has questions
- **Telephone No.:** Identify the telephone number of the contact person (Including Area Code)

SECTION V: Program Category

Check the appropriate program from which recipient is eligible to receive requested service (Select only 1 program per request)

SECTION VI: Service Category

Check the appropriate category to which request refers (Select only 1 service category per request)

SECTION VII: Request Information

- **Procedure Code:** Procedure code (Revenue, HCPCS, or NDC Code) which identifies the specific service being requested, must be completed for request to be considered

  If a specific code is not established, please provide a complete narrative description of service being requested in the Provider Comment Section
- **Procedure Modifier:** Use appropriate Procedure Modifier; refer to Billing Chapter of the Provider Manual
- **Units Requested:** Identify Units requested using the established Billing Units; If authorization is needed because more than the established allowable is needed, Only list the amount in excess of the allowable
- **Actual Cost:** Must be completed when requesting service item that requires DMAS consideration for pricing (Request must include a Description, Manufacture name, Catalog number and copy of Purchase Invoice)
- **Total Dollar Requested:** Identify Total Dollars requested based on corresponding Procedure Codes and Units Requested
- **Dates of Service:** Identify Dates of Service for which the corresponding Procedure Codes and Units are Requested

Signature of Provider and Date of Request must appear in Section VII
ATTACH DOCUMENTATION OF MEDICAL NECESSITY; IF A HOME HEALTH PARTICIPANT, THE HOME HEALTH PLAN OF CARE MUST BE ATTACHED

SECTION VIII: DMAS USE ONLY - DO NOT WRITE IN THIS SECTION

MAIL TO: ATTENTION_____UNIT
DMAS PRACTITIONER
P. O. BOX 27444
RICHMOND, VIRGINIA 23261-7444

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (_____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY